MARYLAND STATE BOARD OF DENTAL EXAMINERS
SPRING GROVE HOSPITAL ? CENTER BENJAMIN RUSH BUILDING
55 WADE AVENUE ? CATONSVILLE, MARYLAND 21228
Phone – 410-402-8501 ? Fax – 410-402-8505 ? www.dhmh.state.md.us/dental/

CHANGE OF INFORMATION REQUEST

The law requires that dentists and hygienists shall notify the Board in writing within 60 days of any change of office address. This is very important since the Board is required only to attempt to contact you at the address you have on record.

The Board is authorized to proceed with its duties, including discipline, after it has attempted to contact you at the address of record, with or without your participation. Failure to notify the Board of an address change may result in your failure to receive a renewal application, which may in turn lead to disciplinary action for practicing on an expired license.

The Board must, by law, have a valid address for you. The address that you provide is the "address of record" that is available for public information requests. The Board does not send licenses, registrations, or certifications to post office boxes. Please provide a full mailing address and a phone number at which you can be reached during the day.

Untimely notification to the Board of an address change will result in a late fee of $10.

Name of Record:		License Number:	
Notice for Mailing List The information collected is for the purposes of the Board's functions under the Md. Health Occ. Code Ann., Title 4. You have a right to inspect, amend, and correct this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. The Board may sell or provide a list of licensees' names and addresses to professional associations and other entities. Under the Maryland Public Information Act, Md. State Gov't Code Ann. §10-617, you may request in writing that your name be omitted from such lists.			
PLEASE DARKEN THE APPROPRIATE BOX			
What information has changed? ? Name ? Home Address ? Work Address ? E-mail Address ? Home Phone Number ? Work Phone Number			
NAME CHANGE			
Previous Name:		New Name:	
If you are requesting a change of name, please submit a copy of a legal name change document, marriage certificate, or divorce decree.			
ADDRESS CHANGE			
Old Mailing Address		**New Mailing Address**	
Is this your ? work or ? home address?		Is this your ? work or ? home address?	
Street:		Street:	
City:		City:	
State:	Zip:	State:	Zip:
PHONE NUMBER CHANGE			
Home Number		**Work Number**	
Old: ( )		Old: ( )	
New: ( )		New: ( )	
E-MAIL ADDRESS CHANGE			
New E-Mail Address:			
I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Further, I authorize the Board to update their records to reflect this information. Signature: _____ Date: _____			
For Office Use:			
Date Received:		Date Processed:	